DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/19/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185257	A. BUILDING _____ B. WING _____	08/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER-GREEN HILL	213 INDUSTRIAL ROAD GREENSBURG, KY 42743

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted on August 3-5, 2010. Deficient practice was identified with the highest scope and severity at "F" level.	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	8/20/10
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and	F 225	F 225 1) On 8/6/10 a complete audit of all the new hires for the year of 2010 was completed. There were no other new hires missing the Nurse Aide Abuse Registry. 2) Residents have the potential to be affected by the deficient practice. Human Resources Coordinator to ensure all new hires have evidence of Nurse Aide Abuse Registry checks are completed. 3) The Human Resources Coordinator has updated the Personnel File Check list to included Abuse Registry, and will complete audits upon hire to assure Abuse Registry checks have been completed. 4) The Human Resources Coordinator will present information to the QA &A Committee monthly and/or as needed for three months, then at least quarterly, to assure the Nurse Aide Abuse Registry is completed for each new employee.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Donna Holmes	ED	8/26/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to properly screen an employee prior to employment. One (1) of five (5) employee records failed to contain evidence the Nurse Aide Abuse Registry had been checked prior to employment to ensure the employee was appropriate for employment in a nursing home. The findings include: On August 5, 2010, the personnel files of five employees were reviewed. This review revealed the Nurse Aide Abuse Registry had not been checked for one of five employees prior to employment. Record review revealed the Administrator was hired on May 3, 2010, and the Nurse Aide Abuse Registry had not been checked until June 29, 2010, to ensure there were no findings of abuse/neglect in the system for this employee that would indicate the employee was not appropriate for employment in a nursing facility. An interview with the Business Office Manager (BOM) conducted on August 5, 2010, at 1:55 p.m., revealed the Administrator had been hired by Corporate on May 3, 2010, and all paperwork was conducted by Corporate. However, once the facility received the paperwork done by Corporate it was discovered a review of the Nurse Aide Abuse Registry had not been conducted. The	F 225		

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F 225	Continued From page 2 Business Office Manager revealed that the Human Resources Coordinator discovered this oversight and conducted a review of the Nurse Aide Abuse Registry on June 29, 2010.	F 225		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: The facility failed to develop an individualized comprehensive care plan for one (1) of twenty (20) sampled residents (resident #13) related to incontinence. Resident #13 was identified to be frequently incontinent of bladder, however, the plan of care for resident #13 was not individualized to address the resident's frequent incontinence episodes.	F 279	F 279 1)Resident #13 care plan does address the resident's Incontinence plan according to the Bladder Tracking Assessment. The plan of care includes the interventions and goals relating to the Resident's Bladder Status and individualized needs. 2) Residents who have been identified through the MDS Assessment and the 3 Day Voiding Pattern Tracking process as being incontinent and having frequent incontinent episodes have the potential to be affected. Residents currently with incontinence will be reassessed to assure the care plan reflects the resident's current need for incontinence plans. 3) Residents will have an assessment completed by the charge nurse at least quarterly, annually, and/or significant changes related to their incontinence patterns and care plans will com implemented/updated and individualized according to their current incontinence pattern. This information will be communicated to the nursing staff for implementation. Residents in the facility will be assess upon admission, readmission,	9/16/10

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F 279	Continued From page 3 The findings include: Observations of resident #13 sitting in the front lobby of the facility on August 3, 2010, at 1:10 p.m. EDT, revealed the resident's clothing was wet with urine. Observations on August 4, 2010, at 1:05 p.m. and 1:35 p.m., revealed resident #13 sitting in the lobby wearing wet pants. Observation of resident #13 at 2:05 p.m. EDT on August 4, 2010, revealed the resident was sitting in the dining room eating lunch wearing the same wet pants. Observation of the resident at 4:00 p.m. on August 4, 2010, revealed the resident sitting in the facility lobby wearing wet pants and a wet shirt. On August 5, 2010, at 11:30 a.m., resident #13 was observed to be sitting in the lobby socializing with staff and other residents, wearing wet pants. A review of the medical record for resident #13 revealed the resident was admitted to the facility on December 13, 2001, with diagnoses that included Mental Retardation, Cerebral Palsy, Hypertension, Depression, Aphasia, Arthritis, and Hypothyroidism. An annual comprehensive Minimum Data Set (MDS) assessment completed on December 23, 2009, revealed resident #13 to be totally incontinent of bladder. A review of the resident's comprehensive care plan revealed the staff was to provide "incontinence management program" for resident #13. The resident was not interviewable due to cognitive impairment and aphasia. An interview with a Licensed Practical Nurse (LPN) conducted at 11:15 a.m. on August 5, 2010, revealed the incontinence management	F 279	quarterly and with any change in condition concerning their Bladder Status. Individualized care plans will be developed relating to findings of the assessment. Nursing staff will be re-in serviced for incontinence management and plan of care for residents to include any changes related to the resident's incontinence patterns. In service on 9/2/10 Licensed Nurses, DNS, ADNS, and Guardian Angel Round Members will observe residents for episodes of incontinent management. The findings will be discussed at Enhanced Start-up and Morning Stand-up meeting daily. The DNS and ADNS will monitor monthly for three monthly and then at least quarterly. 4) The audits will be brought to monthly QA&A committee for review. Any concerns will have action plans developed as indicated.	

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F 279	Continued From page 4 program meant that residents were checked and briefs were changed every two hours. An interview conducted with the Certified Nursing Assistant (CNA) on August 5, 2010, at 11:20 a.m., revealed the direct care staff was to check the Nurse Aide Care Plan for information related to the care of residents. The CNA stated when a resident was incontinent, staff was to check and change the resident every two hours routinely. An interview with the Registered Nurse (RN) conducted at 11:40 a.m. on August 5, 2010, revealed the RN completed the quarterly incontinence assessment for resident #13. The RN stated there were no changes identified in resident #13's incontinence. The RN further stated the resident "probably did need checking and changing more often than every two hours" and that the resident's care plan was not individualized to address the resident's frequent incontinence.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure Foley catheter care was provided in accordance with acceptable standards of practice for one (1) of twenty (20) sampled residents. Resident #8's Foley catheter bag was observed attached to a raised side rail above the level of the resident's bladder on August 3, 2010.	F 281		

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F 281	Continued From page 5 The findings include: Observations of resident #8 conducted during the initial tour on August 3, 2010, at 12:05 p.m. Eastern Daylight Time (EDT), revealed the resident's Foley catheter drainage bag was attached to the top of a raised side rail on the left side of the resident's bed above the level of the resident's bladder. Additional observation revealed the Foley catheter bag was uncovered and in full view. An interview conducted with the Unit Charge Nurse on August 3, 2010, at 12:05 p.m. EDT, revealed the Charge Nurse was not aware why the catheter bag was not covered and was attached to the raised side rail above the level of the bladder. The Charge Nurse stated the catheter bag should be positioned below the level of the bladder for drainage and covered to promote dignity. An interview conducted on August 5, 2010, at 10:30 a.m. EDT, with the Certified Nurse Aide (CNA) who had provided care to resident #8 revealed that when the resident was transferred the CNA overlooked the resident's catheter bag and did not attach the bag to the bed below the level of the bladder. A review of the the facility policy for catheter care (procedure 245), which was undated, revealed a justification diagram that indicated the catheter and tubing was to be checked for proper drainage and positioning. The policy stated to provide a catheter bag cover to promote dignity.	F 281	F 281 1) Resident # 8's catheter bag and tubing was repositioned on side of bed blow the bladder to promote drainage. A catheter bag cover was on Resident #8's wheelchair and a second catheter bag cover was obtained and placed on the side of the bed for the catheter bag. 2) Current residents with foley catheters were assessed for positioning of tubing, and cover of drainage bag. No other residents were affected. 3)Licensed Nurses, DNS, ADNS, and Guardian Angel Round Members will monitor positioning of catheter tubing and ensure draining bags are covered daily during rounds. The findings will be discussed at Enhanced Start-up and Morning Stand-up meeting daily. The DNS or designee will monitor monthly for three months and then at least quarterly. Nursing staff will be in serviced related to catheter care on 9/2/10. 4) The audits will be brought to monthly QA&A committee for review. Any concerns will have action plans developed as indicated.	9/9/10
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 6 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that food was stored, prepared, and served under sanitary conditions. Observations in the kitchen revealed the the staff's handwashing lavatory did not have paper towels, a black substance was noted on the wall behind the dish machine, and the water was leaking into the presoak liquid. The dish machine, convection oven, and warming table were observed to have a buildup of carbon, food debris, and grease, the Dietary Manager was observed to be in the food production area with unrestrained hair, the sanitizing solution bucket for towels was unclean, and the dry storage bins and the floors were observed to be soiled. The ice scoop was observed lying on the top surface of the milk cooler. Flies were observed throughout the kitchen, on food and surfaces. The Dietary Manager was observed to cook meat outdoors on a grill located adjacent to a cart containing trash and garbage, the outside ice cream freezer was observed to have a buildup of frost on the inner surface, and the milk cooler contained frozen milk. Observation of the tray line revealed buttered toast was stored on the shelf above the warming table without a heat	F 371	F 371 The black substance has been cleaned from the wall behind the dish machine and in on a regular cleaning schedule. The sanitation buckets have been cleaned and are on a regular cleaning schedule. The dry storage food bins have been cleaned and are on a regular cleaning schedule. Paper towels were replaced in dispenser and monitored for replacement regularly. Coleslaw and cold items are no longer stored on top of the warming table. They are stored in the refrigerator until service time. The leak from the silverware presoak has been repaired. The dish machine has been cleaned and the grease build up and food debris has been removed-and placed on regular cleaning schedule. All employees with facial hair are wearing beard nets when in the kitchen. Beard nets have been purchased and available. The grill has been relocated to the courtyard away from any trash bin or debris.	9/17/10

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F 371	Continued From page 7 source, and coleslaw was observed to be stored unrefrigerated and uncovered on the warming table. The findings include: 1. On August 3, 2010, at 12:20 p.m. (Eastern Daylight Time), during the initial dietary tour, the towel holder located above the dietary hand sink was observed to be empty. There were no disposable towels available for the dietary staff to dry their hands. An interview was conducted with the facility dietitian at 12:30 p.m. on August 3, 2010. The facility dietitian stated the dietary staff was responsible to replace the disposable towels. 2. Observation at 12:35 p.m. on August 3, 2010, of the warming table revealed an unrefrigerated, uncovered prepared container of cole slaw placed on the top shelf of the warming table. The temperature of the the coleslaw taken by the facility dietitian at 12:35 p.m. on August 3, 2010, revealed the temperature of the coleslaw to be 77 degrees Farenheit, above the established standard temperature of 41 degrees Farenheit for potentially hazardous foods. An interview was conducted with the facility dietitian on August 3, 2010, at 12:35 p.m. The facility dietitian stated the coleslaw was unsafe to use at that temperature and discarded the container of coleslaw. 3. Observation of the facility dishwasher at 12:40 p.m. on August 3, 2010, revealed a stream of water leaking from the silverware pre-soak	F 371	The outdoor ice cream freezer has been defrosted and is on a regular defrosting schedule. Dietary staff has been instructed to dispose of any frozen milk that is removed from the cooler. The milk cooler thermostat was adjustment and no other milk has been observed to be frozen and correct temperatures are maintained. The toast has been placed on the buffet table to maintain adequate and palatable temperature. Ice scoop was washed and properly stored. Staff has been instructed on proper storage. The facility contracted Ecolab to begin the Fly Program which starting on 8/17/10. The warming table has been cleaned and is on a regular cleaning schedule. The convection ovens have been cleaned are on a regular cleaning schedule. Hair restraints are in place and a sign has been posted to wear hair nets/hair restraints when entering the Kitchen.	

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F 371	Continued From page 8 container. The water was leaking into the bucket containing the facility dishware and presoak. The excess water was diluting the silverware presoak. In addition, an empty plastic Coca-Cola bottle was placed behind the metal water conduit. An interview with the facility dietitian was conducted on August 3, 2010, at 12:45 p.m., revealed the bottle had been placed behind the metal conduit to prevent the water from leaking on the adjacent wall. In addition, an area of black substance was observed to be on the wet wall behind the dish machine. The facility dietitian was unsure of the length of time the conduit had been leaking. 4. Observation of the external surface of the facility dish machine on August 3, 2010, at 12:46 p.m., revealed the dish machine to have a buildup of grease and food debris. An interview was conducted with the facility dietitian on August 3, 2010, at 12:47 p.m. The facility dietitian stated the Dietary Department had several inexperienced newly hired staff members. The dietitian further stated the Dietary Department's main objective recently was to ensure the residents had food. 5. Observation of the Dietary Manager on August 3, 2010, at 12:46 p.m., revealed the Dietary Manager to be in a food production area with unrestrained facial hair. An interview conducted with the Dietary Manager on August 3, 2010, at 12:47 p.m., revealed he/she was unaware facial hair had to be covered or restrained. 6. The Dietary Manager was observed to grill meat outside the kitchen on August 3, 2010, at	F 371	The dry storage bins have been cleaned are on a regular cleaning schedule. The floor under equipment and in hard to reach areas have been cleaned and are on a regular cleaning schedule. Residents have the potential for being affected by the deficient practice. The Dietary Manager, Maintenance Director, Facility Dietician and Executive Director have in serviced all Dietary staff related to sanitation, food safety, cleaning schedules and assignment related to these areas on 8/20/10. Cleaning schedules have been adapted to the include the issues noted during and posted. Cleaning schedules will be monitored daily by the Dietary Manager. The Executive Director will make weekly rounds in dietary to assure sanitation and food safety are maintained. The Facility Dietician will make quarterly sanitation rounds. The Dietary Manager will report in morning stand up any issues found. 4) Issues will be discussed monthly with QA&A Committee to determine effectiveness of action plan and need for other actions.	

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F 371	Continued From page 9 1:00 p.m. (Eastern Daylight Time). Adjacent to the the portable grill utilized to cook the meat for the residents was a large trash cart containing two large bags of discarded food and trash. Foul odors were noted from the trash container. Flies were observed to be landing/crawling on the external surface of the trash cart. The facility dietitian revealed in an interview at 1:00 p.m. on August 3, 2010, that staff was unaware utilizing a grill in close proximity to a trash container would be unsanitary. 7. Observation of the small ice cream freezer which was located outdoors permanently revealed a one-fourth-inch buildup of frost/ice on the inner surface of the freezer. Four of the individual ice cream containers had melted and refrozen. An interview conducted with the facility dietitian on August 3, 2010, at 1:10 p.m., revealed none of the facility staff could remember when the ice cream freezer had been cleaned/defrosted. 8. On August 3, 2010, at 1:10 p.m., the dietary milk cooler was observed to contain two cases and five single pints of frozen whole milk. An interview was conducted with the facility dietitian on August 3, 2010, at 1:15 p.m. The facility dietitian stated the staff was unaware the milk was freezing. The facility dietitian contacted a representative of the milk company on August 3, 2010. The milk company representative revealed the shelf life of milk would be shortened and the expiration date stamped on the milk carton would be unreliable.	F 371		

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F 371	Continued From page 10 9. Observation of the breakfast tray line assembly conducted on August 4, 2010, at 8:30 a.m., revealed the pre-toasted/pre-buttered bread to be served to the residents at breakfast was placed in a stainless steel one-quarter deep pan on the shelf above the warming table without a heating source. An interview was conducted with the Dietary Manager on August 4, 2010, at 8:40 a.m. The Dietary Manager stated the current toast would be cold and unpalatable. The Dietary Manager further stated the toast should be toasted at the time the tray is assembled. 10. On August 4, 2010, at 8:50 a.m., the dietary ice scoop utilized by dietary staff to scoop residents' ice was observed to be lying flat on the external surface of the milk cooler; however, the ice machine was located outside the dietary area in the hallway. An interview was conducted with the facility dietitian on August 4, 2010, at 8:50 a.m. The facility dietitian stated the ice scoop was stored improperly and would have to be cleaned prior to staff using the scoop to dip ice. 11. Observation on August 4, 2010, at 8:55 a.m., revealed the pre-portioned bowls of oatmeal were on a tray on the shelf of the warming table. Flies were observed landing/crawling on the external surface of the bowls. An interview was conducted with the Dietary Manager on August 4, 2010, at 9:00 a.m. The Dietary Manager stated the flies had been a problem for a while. The Dietary Manager stated the staff sprayed but the flies came back.	F 371		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 11 12. Observation made during the final sanitation audit conducted on August 5, 2010, at 2:30 p.m., revealed the warming table utilized to maintain foods served to residents contained burned food debris and a heavy buildup of carbon around/under the heating element(s) of all four deep wells. An interview was conducted with the Dietary Manager on August 5, 2010, at 2:35 p.m. The Dietary Manager stated he had bought oven cleaner the previous evening. Dietary staff was not able to reveal when the four heating wells had been cleaned. 13. Observations on August 5, 2010, at 2:45 p.m., revealed the dietary convection oven had a buildup of grease and carbon on the inside metal racks and external/internal surface of the convection oven. An interview was conducted with the Dietary Manager on August 5, 2010, at 2:46 p.m. The Dietary Manager was unsure when the oven had been cleaned. 14. Observation of the Dietary Manager on August 5, 2010, at 2:50 p.m., revealed the Dietary Manager was wearing the facial hair restraint but was missing the hair restraint on his/her head while in a food production area. An interview was conducted with the Dietary Manager on August 5, 2010, at 2:56 p.m. The Dietary Manager stated he forgot to put the hair restraint on his head. 15. Observation of the large dry storage bins on	F 371		

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	185257	A. BUILDING _____ B. WING _____	08/05/2010

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F 371	Continued From page 12 August 5, 2010, at 3:00 p.m., revealed spills of food and liquids on the external surface of the bins. An interview was conducted with the facility dietitian on August 5, 2010, at 3:00 p.m. The facility dietitian was unable to determine when the bins had been cleaned by the dietary staff. 16. Observation on August 5, 2010, at 3:05 p.m., revealed the Dietary Department floors under equipment and in hard-to-reach areas were unclean, with food debris and paper. An interview was conducted with the facility dietitian on August 5, 2010, at 3:10 p.m. The facility dietitian stated the facility had a schedule for routine floor cleaning; however, none of the staff was aware when floors had been cleaned last. A record review of the undated dietary cleaning schedule(s) provided by the facility dietitian for the weeks prior to the survey revealed the cleaning schedule had been signed intermittently with whole days not signed at all. An interview with the facility dietitian conducted on August 4, 2010 at 11:55 a.m., revealed the facility's previous Dietary Manager had left six weeks ago and Dietary Managers from sister facilities had been "filling in" until a permanent replacement was found. The dietitian stated the interim Dietary Managers should have monitored cleaning tasks and documented their completion. An interview was conducted with the interim Dietary Manager on August 4, 2010, at 5:00 p.m. EDT, revealed a temporary Dietary Manager had	F 371		

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F 371	Continued From page 13 been responsible for the dietary staff cleaning assignments and to ensure the assignments were completed. An interview with the facility dietitian conducted on August 3, 2010, at 12:20 p.m., revealed the emphasis had been more on "getting the food out" rather than cleaning and sanitation.	F 371		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a safe, functional, and sanitary environment for residents, staff, and the public. Environmental observations revealed soiled medication carts, torn dining room shades, dust buildup on window sills, and scarred closet doors. The findings include: 1. Observations of the medication carts on the North and South Wings conducted on August 5, 2010, from 1:15 p.m. to 1:45 p.m. Eastern Daylight Time (EDT) revealed four medication carts with a buildup of dirt and medication debris on the sides of the carts and on the cart bumpers. An interview conducted with the Director of Nursing on August 5, 2010, at 1:45 p.m. EDT, revealed the carts were cleaned weekly on	F 465	F 465 1) The medication carts were immediately cleaned. A cleaning schedule has been posted and assigned. The window sills on North and South Wings and the piano were immediately cleaned. The couches on North Wing were immediately cleaned. The routine cleaning schedule was adapted to include these areas. The closet doors in Room 1 and 12 have been painted. The broken air conditioner covers have been replaced. Loose/torn wall paper has been repaired. The hole in the drywall on South has been repaired. The hole in the North wing with the exposed water pipe is scheduled for repair on 8/31/10. 2) Residents have the potential for being affected by the deficient practice.	9/9/10

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F 465	Continued From page 14 Fridays by Nursing and that Pharmacy and Maintenance would pressure-wash the carts periodically on an as-needed basis. A review of the nursing calender for August 2010 revealed the medication carts were scheduled to be cleaned by Nursing every Friday. 2. Observation of the North and South Wing dining rooms conducted on August 5, 2010, at 11:00 a.m. EDT, revealed dust buildup on window sills in the North and South Wing dining room, and dust buildup on a piano on the North Wing. A resident couch with soiled fabric was observed on the North Wing. An interview conducted with the Housekeeping Supervisor on August 5, 2010, at 11:00 a.m. EDT, revealed that the housekeepers were required to clean and dust daily, however, had not dusted the window sills or the piano. Further interview revealed the Housekeeping Supervisor was not aware the couch was in need of cleaning. 3. An environmental tour was conducted with the Maintenance Director on August 5, 2010, at 11:15 a.m. EDT. Observations conducted during the tour revealed scarred closet doors in resident rooms 1 and 12, two broken air conditioner covers in the South Wing dining room, torn/loose wallpaper in the South Wing dining room and near the main entrance, a hole in the drywall in the South Wing dining room partially covered with tape, and a hole in the wall in the North Wing dining room with an exposed water pipe protruding from the wall. An interview conducted with the Maintenance Director on August 5, 2010, at 11:30 a.m. EDT,	F 465	3) The Housekeeping Supervisor has in serviced staff related to following cleaning schedule completed by 8/31/10. The Maintenance Director has in-serviced staff related to the use of Building Engines to log any repairs needed completed by 9/2/10. The Executive Director will make weekly rounds with the Housekeeping Supervisor and Maintenance Director to assure cleaning schedules and repairs are completed and any issues identified to be completed. The Housekeeping Supervisor and the Maintenance Director will report any issue noted in the morning stand up meeting and monthly in the QA &A meeting. 4) Issues will be discussed monthly with QA&A Committee to determine effectiveness of action plan and need for other actions, until resolved. The Executive Director is responsible for overall compliance.	

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F 465	Continued From page 15 revealed the Maintenance Director was not aware of the broken air conditioner covers, or the torn/loose wallpaper. The Maintenance Director had recently removed a water fountain but had not removed the water pipe nor had considered the pipe a hazard for residents. Additional interview revealed the Maintenance Director was made aware of items in need of repair by staff entering the items in the computer and the Maintenance Director printed the work order off each day. There was no evidence provided of recent work orders to include the identified items in need of repair.	F 465		
F 469 SS=F	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain an effective pest control program so the facility was free of pests. Flies were observed throughout the facility from August 3-5, 2010. The findings include: Observations conducted during the initial tour on August 3, 2010, at 12:05 p.m. Eastern Daylight Time (EDT), revealed two flies on the South Wing in the hallway near room 118. Observations of the North Wing dining room conducted on August 3, 2010, at 3:40 p.m. EDT,	F 469	F 469 1) A new contract with ECOLAB has been executed for the Fly Program. Maxima lights has been placed in high traffic areas of the facility and a monthly treatment for flies has been started. 2) Residents have the potential for being affected by the deficient practice. 3) The Maintenance Director will monitor the effectiveness of the Fly Program daily and report any issue immediately to ECOLAB. The Maintenance Director will report any issue noted in the morning stand up meeting. 4) Issues will be discussed monthly with QA&A Committee to determine effectiveness of action plan and need for other actions.	9/9/10

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F 469	Continued From page 16 revealed two flies flying around seated residents. A resident was observed to kill two flies with a fly swatter in the North Wing dining room on August 4, 2010, at 9:50 a.m. EDT. Observations of the noon meal conducted on August 4, 2010, at 1:47 p.m. EDT, revealed two flies in the South Wing dining room. The flies were observed to light on resident drinking glasses. An interview was conducted with resident #1 on August 3, 2010, at 5:00 p.m. EDT. Resident #1 stated, "The flies bother me every time I try to eat." Resident #1 also stated, "The flies try to to get in my food when I try to eat." An interview conducted with the Maintenance Supervisor on August 5, 2010, at 11:30 a.m. EDT, revealed the facility was treated every month by a pest control company. Further interview revealed the pest control company did not treat for flies and the facility did not have a system to address the flies. A review of pest control invoices for the months of May 2010, June 2010, and July 2010 revealed the pest control company had not treated the facility for flies. A review of the facility's ongoing pest control contract dated October 23, 2007, revealed the contract did not address treating for flies.	F 469		

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	185257	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/03/2010

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K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on August 3, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on interview, the facility failed to utilize proper access doors in the fire/smoke wall assembly in the attic area. This deficient practice affected eight (8) of eight (8) smoke compartments, staff, and approximately ninety-eight (98) residents. The facility has the capacity for 106 beds with a census of 98 on the day of survey. The findings include: During the Life Safety Code survey on August 3,	K 025	K 025 It is the practice of the facility to assure required smoke barriers be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. 1)Proper access doors will be replaced in the fire/smoke wall assembly in the attic area on 8/31/10. 2) Residents have the potential to be affected by this deficient practice. 3) Smoke barriers will be inspected quarterly and after any vendors have worked in the attic to assure compliance. Inspections will be logged in Maintenance Binder. 4) Inspections will be reviewed by the QA&A Committee quarterly to assure continued compliance for one year following noted issue.	8/31/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Norma Jones RD | 8/26/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 025	Continued From page 1 2010, at 1:55 p.m., an interview with the Director of Maintenance revealed the facility had seven unapproved makeshift doors in the fire/smoke barrier walls in the attic area. This type of access door is required to be an approved device that is designed for the specific purpose to help prevent fire/smoke from spreading to other areas of the building in a fire situation. An interview with the Director of Maintenance on August 3, 2010, at 1:55 p.m., revealed the Director of Maintenance had not been made aware in the past that these doors were deficient. The Director of Maintenance stated the door assemblies were made of plywood sandwiched between two rated panels of sheetrock. The Director of Maintenance stated the doors were spring loaded and sealed the fire/smoke walls completely. The doors in the attic area were not observed due to excessive heat on the day of the survey. Reference: NFPA 101 (2000 Edition). 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air	K 025		

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K 025	Continued From page 2 ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose.	K 025		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		

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K 062	Continued From page 3 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to maintain the sprinkler system by NFPA standards. The findings include: During the Life Safety Code tour on August 3, 2010, at 12:30 p.m., an interview with the Director of Maintenance at the facility's sprinkler room revealed the Director of Maintenance did not think the gauges to the sprinkler system had been replaced or recalibrated within five years as required. On August 3, 2010, at 1:45 p.m., a record review of the sprinkler system inspection reports did not show if the gauges had been serviced or replaced in the past. Reference: NFPA 25 (1998 Edition). 2-3.2* Gauges. Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced.	K 062	K 062 It is the practice of the facility to assure required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 1) The gauges to the sprinkler system were replaced and calibrated on 8/17/10. 2) Residents have the potential to be affected by this deficient practice. 3) The Maintenance Director and the Licensed Contractor will inspect the gauges, calibrate and replaced according to NFPA 25 and will log in the Maintenance Binder. 4) Inspections will be reviewed by the QA&A Committee quarterly to assure continued compliance for one year following noted issue.	8/17/10